Atypical Providers

The information below is a list of important fields on the CMS-1500 claim form for providers that bill using an atypical provider number. Fields not listed are not needed to process a claim for Montana Medicaid.

Member Has Medicaid Coverage Only

CMS-1500

Field #	Field Title	Instructions
Member Information		
2*	Member's Name	Enter patient's name as seen on member's Montana Health Care Programs information.
10d, *	Member's ID	Enter the member's ID number as it appears on the member's Montana Health Care Programs information.
1a, 9a, 11**	Member's ID	If member's ID is not located in 10d, these three fields are searched for the number.
Provider Information		
31*	Signature and Date	Enter signature and date.
33*	Billing Provider Info	Enter physical address with a 9 digit ZIP code and phone number.
33a**	NPI #	Enter NPI number for billing provider. If billing with a proprietary ID, leave 33a blank.
33b**	Taxonomy # Proprietary ID	Enter the qualifier (ZZ) and the billing provider's taxonomy code. Enter the G2 qualifier and the billing provider's Montana Health Care Programs number.
Billing Information		
21.1 – 21.4*	Diagnosis codes	Enter at least one diagnosis.
24a*	Date(s) of Service	Enter the dates of service; include beginning and ending date even if same.
24b*	Place of Service	Enter the code for place of service
24c**	EMG	Emergency indicator if applicable
24d*	Procedure Code	Enter the procedure code used/ Enter modifiers if applicable
24e*	Diagnosis Pointer	Enter the corresponding diagnosis pointer (1, 2, 3, or 4) that refers to the codes in field 21.
24f*	Charges	Enter the total charge for this line.
24g*	Days/Units	Enter the days or units used for the procedure.
24h**	EPSDT Family Plan	Enter 1 when the member is under age 21. Enter 2 when providing family planning services. Enter 3 when the member is under age 21 and is receiving family planning services. Enter 4 when providing services to pregnant women. Enter 6 when providing services to nursing facility residents.
28*	Total Charges	Enter total charges from all line items.

* = Required Field ** = Conditional (Required if applicable)

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Medicaid Only Coverage / Atypical Prov.

Fill Colors:
- Required Fields
- Conditional Fields
- Other

Boarder Colors
- Client Fields
- Provider Fields
- Billing Fields

PICA

1. MEDICARE (Medicare #) | MEDICAID [X] (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Flintstone, Fred T

3. PATIENT'S BIRTH DATE: 08 30 60 SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 112 Rocky Rd.

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: Bedrock | STATE: BC

8. PATIENT STATUS: Single [ ] Married [X] Other [ ]

CITY | STATE

ZIP CODE: 54321-1234 | TELEPHONE (Include Area Code): (406) 765-4321

Employed [X] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE | TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: Medicaid

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE: 123456789

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY 01 01 07 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 799.9

3.

2.

4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										ID	0054321
01 01 07	01 01 07	11	0	A0140		1	100 00	1	Y	NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 99-9999999 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 123456789

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 100 00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 100 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Rocky Shalstone 01/01/07

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH #: (406) 555-1234

Yabba-Dabba Cab service
2121 Granite Slab Dr.
Bedrock, MT 54321-1234

a. NPI G2 005321

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)